ENROLLMENT

NCI/DCTD/CTMS CASE REPORT FORM

Date Completed (dy/mth/yr)	Protocol #	Institution	Patient ID

Sex (circle): M F	Date of Birth (dy/mth/yr):	Age:

Race: *check one or more* [ ] 01 White [ ] 06 American Indian or Alaska Native [ ] 03 Black or African American [ ] 99 Unknown [ ] 04 Native Hawaiian or Other Pacific Islander [ ] 05 Asian	Ethnicity: [ ] 9 Unknown [ ] 1 Hispanic or Latino [ ] 2 non-Hispanic

Body Weight (kg):	Height (cm):	Body Surface Area (m^2):

CTEP Patient Subgroup:	Institution's Patient ID: *(if different from ID for CTMS)*

Registering Group (CTEP code): *(for inter-group trials only)*	Country Code:	Postal Code:

Registering Institution (CTEP code):	Method of Payment**:

Primary Site:	
Stage of Disease:	CTEP Disease Code: *(from CTEP Web Site or Help Desk)*
Histology/Cytopathology:	
Date of Confirmation of Histology (dy/mth/yr):	Grade of Histology:
Date of Diagnosis (dy/mth/yr):	Performance Status:
Informed Consent Signature Date (dy/mth/yr):	Registration Date (dy/mth/yr):
Informed Consent Version: _____	Planned Treatment Assignment Code:

**Method of Payment Codes

1 = Private Insurance
2 = Medicare
3 = Medicare and Private Insurance
4 = Medicaid
5 = Medicaid and Medicare
6 = Military or Veterans Sponsored NOS
6a = Military Sponsored (including CHAMPUS &TRICARE)
6b = Veterans Sponsored
7 = Self Pay (No Insurance)
8 = No means of payment (no insurance)
98 = Other
99 = Unknown

EN: THX-CTMS-REV.03A